



## **Texas Department of Insurance**

### **Division of Workers' Comp**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DALLAS COUNTY HOSPITAL  
P O BOX 455  
DALLAS TX 75266 0599

#### **Respondent Name**

INSURANCE CO OF THE STATE OF PA

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-4748-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Claim did not pay per drg"

**Amount in Dispute:** \$4,615.66

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this dispute.

**Response Submitted by:** N/A

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2011 Through January 27, 2011	Inpatient Hospital Surgical Services	\$4,615.66	\$4,615.66

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute..
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

- (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”
  - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- Explanation of benefits dated March 4, 2011
- 1 -W1 –Workers Compensation State Fee Schedule Adjustment.
  - 1 - No Reduction Available. (VRNA)
  - 2 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
  - \* - Any request for reconsideration of this workers’ compensation payment should be accompanied by a copy of this explanation of review. (Z656)

## **Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to reimbursement for the disputed services?

## **Findings**

1. No documentation was found to support a contractual agreement between the parties to this dispute. Therefore, the Division concludes that the disputed services are not included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:  
 The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 578 is \$12,525.29.  
 This amount multiplied by 143% is \$17,911.16.  
 The total maximum allowable reimbursement (MAR) is \$17,911.16.  
 This amount less the amount previously paid by the respondent of \$13,295.07 leaves an amount due to the requestor of \$4,616.09.  
 The requestor’s *Table of Disputed Services* lists the total amount in dispute as \$4,615.66.  
 The Division concludes that the requestor is entitled to \$4,615.66 additional reimbursement.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4,615.66.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$4,615.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	<u>Debra Hausenfluck</u>	<u>1</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**